Kattie Bachar M.A. AMFT 110355 Associate Marriage and Family Therapist 805-620-7547

Supervised by Bren J Fraser LMFT 45649

Legal Name

Preferred Name:

Date of Birth: / /

Sex Assigned at Birth: • M • F • Intersex

Gender: • M • F • Other

Pronouns: • He/Him/His • She/Her/Hers • They/Them/Theirs • Other Do you have a faith-based or spiritual practice?

Address:

Phone number(s) / Email address:

Emergency Contact:

Marital Status: • Married • Single • Divorced • Separated • Remarried

* Committed relationship • Partnered • Widowed

Education/Highest Grade Completed:

Occupation/Employer:

Presenting problem/reason for seeking treatment:

Besides therapy, how have you tried to manage this problem?

Previous Psychiatric Treatment: • None • Outpatient • Inpatient

* Please describe (reason for treatment, clinician, dates of treatment, outcome:) Psychiatrist’s Name: Psychiatrist’s Phone #: Physician’s Name: Physician’s Phone #: Medical conditions:

Allergies:

Medications:

**Symptom Checklist**

* Victim of abuse
* Neglect
* Unresolved grief/loss
* Irritability
* Excessive sadness
* Loss of enjoyment of usual activities
* Low self-esteem
* Tiredness, fatigue
* Withdrawn, isolation
* Feelings of emptiness
* Difficulty sleeping
* Panic
* Expressing a wish to die
* Poor concentration
* Excessive worry
* Thoughts/attempts of suicide
* Excessive fears (phobias)
* Nervousness
* Workaholic behavior
* Compulsive spending
* Compulsive sexual relationships
* Weight loss/gain Binge eating
* Not eating to lose weight
* Trying to lose weight by vomiting or exercising excessively
* Feelings of detachment
* Hearing voices
* Excessive physical pain
* Seeing things that aren’t there
* Hair-pulling
* Impulsivity
* Disorientation
* Difficulty finishing tasks
* Difficulty paying attention
* Excessive daydreaming
* Stealing
* Lying Hyperactivity
* Recurring problems with the law
* Destroying property
* Cigarette use
* Repeating an act over and over that is unnecessary (e.g., washing, checking, counting)
* Overly concerned about germs, safety, or health
* Excessive need for order, cleanliness
* Overly concerned with details
* Easily annoyed
* Mood swings
* Temper outbursts Argumentative
* Violent fantasies/impulses
* Harmful to others
* Periods of time with very high energy level
* Talking or thinking too fast
* Paranoia
* Poor body image
* Alcohol use: per week
* Drug use
* Questions or concerns with your sexuality
* Questions or concerns with your gender or gender expression
* Participating in high-risk sexual activity
* Difficulty performing sexual activity
* Feel guilty about sex
* Relationship problems
* Overly sensitive to criticism
* Overreactive
* Fear of rejection
* Difficulty trusting

Please indicate the degree of distress you are experiencing at this time:

* Mild • Moderate • Severe

Please describe any notable mental health or behavioral issues of family/relatives

What else do you want me to know about you?

Date: Signature: